



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General
Office of Audit Services

JUN - 7 2004

REGION IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

Report Number: A-04-03-07027

Mr. Rick Harris
Bureau of Provider Health Standards
Alabama Department of Public Health
The RSA Tower
201 Monroe Street
Montgomery, Alabama 36104

Dear Mr. Harris:

Enclosed are two copies of the Office of Inspector General (OIG) final report entitled *Survey of Physical and Sexual Abuse in Alabama Nursing Homes*. The objective of our review was to determine if the Alabama Department of Public Health – Complaint Unit properly investigates, tracks, and monitors physical and sexual abuse in nursing facilities in a timely manner.

Final determination as to actions taken on all matters reported will be made by the Department of Health and Human Services (HHS) action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

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To facilitate identification, please refer to report number A-04-03-07027 in all correspondence related to this letter.

Sincerely,

A handwritten signature in black ink, reading "Charles J. Curtis".

Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV

Enclosure – as stated

Direct Reply to HHS Action Official:

Mr. Renard Murray
Associate Regional Administrator
Centers for Medicare and Medicaid Services
Division of Medicaid and Children's Health
61 Forsyth Street, S.W., Suite 4T20
Atlanta, Georgia 30303-8909

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**SURVEY OF PHYSICAL AND SEXUAL
ABUSE IN ALABAMA NURSING
HOMES**



**JUNE 2004
A-04-03-07027**

Office of Inspector General

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OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.



EXECUTIVE SUMMARY

OBJECTIVE

The objective of our review was to determine if the Alabama Department of Public Health – Complaint Unit (Survey Agency) properly investigates, tracks, and monitors physical and sexual abuse in nursing facilities in a timely manner.

SUMMARY OF FINDINGS

Our review of physical and sexual abuse complaints reported to the Survey Agency for calendar year (CY) 2002 revealed that changes should be made to improve the methodology currently used to investigate, track, and monitor physical and sexual abuse complaints as reported by nursing facilities. We found that the Survey Agency:

- Is not investigating allegations within established timeframes. Policies and procedures of the Survey Agency set forth the time limits for reporting and investigating abuse complaints. The Centers for Medicare & Medicaid Services (CMS) requires all recertification surveys to be conducted prior to investigating abuse complaints at nursing facilities. Due to the priority of recertification surveys and resource issues, the Survey Agency is unable to comply with Federal and State regulations that require them to investigate abuse complaints within established timeframes. This practice has resulted in a backlog of abuse complaints for the past 4 years.
- Did not track and monitor all reported incidences of alleged physical and sexual abuse. CMS's State Operations Manual states that Survey Agencies are to establish a file and a system to facilitate tracking and control of all abuse allegations. The Survey Agency used an inconsistent complaint tracking methodology; therefore, there is no assurance that complaints are appropriately addressed.
- Is not providing adequate monitoring of substantiated abuse findings by not timely updating the Alabama Certified Nurse Aide Registry (the registry). According to 42 CFR § 483.156, the Survey Agency is to include substantiated findings of abuse to the registry within 10 working days of the findings. Perpetrators of abuse remain in "Good Standing" on the registry and are free to seek employment in other direct care settings. Thus, the risk for harm to other residents is increased.
- Is not adequately monitoring submissions of abuse complaints by nursing facilities to ensure that they are submitted timely. According to 42 CFR § 483.13, abuse must be reported immediately to the facility administrator and the Survey Agency; also, nursing facility investigation results must be reported to the Survey Agency within 5 working days of the incident. Alabama licensure rules require

nursing facilities to notify the Survey Agency within 24 hours of an abuse occurrence. Our review found that nursing facilities are not submitting complaints within the timeframes prescribed by these criteria. Until abuse complaints are reported and investigated, abuse could continue.

RECOMMENDATIONS

We recommend that the Survey Agency:

- Investigate complaints within established timeframes. We also recommend the Survey Agency notify CMS of all abuse complaint backlogs and request assistance from CMS to help restore the workload to a manageable level.
- Improve policies and procedures to include detailed instructions for tracking and monitoring all complaints received.
- Update the registry in accordance with Federal requirements and place a higher priority on abuse complaints that have already been substantiated by the nursing facilities.
- Encourage nursing facilities and their employees to report abuse allegations in accordance with Federal and State regulations by citing the nursing facilities with deficiencies.

SURVEY AGENCY'S COMMENTS

The Survey Agency did not agree with all of our recommendations or findings. We have revised our final report based on their comments and information provided with their response. The Survey Agency's written comments and the Office of Inspector General's (OIG's) response to the Survey Agency's comments are incorporated into the body of this report. In addition, the Survey Agency's comments are included in their entirety as an appendix. All personal identifiers in the Survey Agency's comments have been redacted.

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INTRODUCTION

BACKGROUND

The focal point for all abuse allegations arising from nursing facilities in the State of Alabama is the Survey Agency. The Survey Agency is required by Federal regulations to provide a methodology for investigating and monitoring abuse allegations. A complaint tracking system known as the Facilities Management System is utilized by the Survey Agency. The Survey Agency is also required to have procedures and adequate staff to investigate complaints or violations of requirements by nursing facilities in a timely manner.

The Survey Agency performs recertification surveys at least every 15 months to assess nursing facilities' compliance with State and Federal regulations. In addition to periodic surveys, the Survey Agency also investigates complaints of physical and sexual abuse. These complaints are reported to the Survey Agency from various sources, but primarily from the nursing facilities.

Once a nursing facility learns of an abuse allegation, Alabama licensure rules require the nursing facility to notify the Survey Agency within 24 hours. Nursing facilities notify the Survey Agency of abuse allegations by submitting an Abuse and Unusual Occurrences Report. The abuse report may be submitted "by telephone (and confirmed in writing), email or facsimile". Once the 24-hour report is sent to the Survey Agency, the nursing facility must investigate the complaint and report the results of the investigation to the Survey Agency within 5 working days of the incident; the results of the investigation are to be mailed to the Survey Agency. The investigation of the complaint should be thorough and should provide appropriate corrective action.

Regardless of the source of the complaint, the Survey Agency is required to review all allegations of resident neglect and abuse. The Survey Agency may wait until the 5th working day investigation has been received from the facility before the complaint is assigned a priority for investigation. Then, the prioritization of the complaint by the Survey Agency depends on the completeness of the facility's investigation, the appropriateness of the conclusions reached during the investigation, and the corrective actions taken by the facility against the perpetrator of the abuse.

Three investigation priorities may be assigned to a complaint as follows:

- (1) Immediate jeopardy – "a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident".
- (2) Actual harm – includes the intimidation and/or threatening of a resident, physical abuse, unexplained or unexpected death, falls resulting in a fracture, inappropriate use of restraints resulting in injury, inadequate staffing which negatively impacts

resident health and safety, and failure to obtain appropriate care or medical intervention.

- (3) All other – includes complaints from residents about cold food, environmental concerns, and staff issues. In some cases, if the Survey Agency has determined the facility has conducted an adequate investigation, the Survey Agency may opt to perform a desk review instead of going onsite to perform an investigation.

If the Survey Agency determines that immediate jeopardy has occurred, the complaint is assigned a priority to investigate within 2 working days of receipt of the complaint. If actual harm is determined to have occurred, then a priority is assigned to investigate within 10 working days of receipt of the complaint. For all other complaints, a priority is assigned to investigate via either the next onsite visit or a desk review. During CY 2002, the period of our review, the investigation would occur during the next recertification survey. If a facility had recently completed a recertification survey, which is conducted every 9 to 15 months, the next onsite visit could be as long as 15 months later. The priority to investigate during next onsite or desk review was applied to all complaints that were not immediate jeopardy or actual harm.

If the Survey Agency determines that a facility has taken appropriate action against an accused licensed individual, the Survey Agency may determine that adequate action has been taken and choose not to investigate the case. The Survey Agency will file the allegation without assigning a complaint number. The action taken in such a situation, if warranted, will involve forwarding the allegation to the appropriate licensing authority. On the other hand, if it appears the facility has not provided adequate documentation of appropriate action taken, then a complaint number and a priority will be assigned to the allegation. For allegations where an individual employed by the facility allegedly neglected or abused a resident, the Survey Agency is required to investigate the complaint. Once the Survey Agency determines that an abuse allegation is substantiated and the appeal process has expired, the Survey Agency has 10 working days to include the finding on the registry.

OBJECTIVE, SCOPE AND METHODOLOGY

Objective

The objective of our review was to determine if the Survey Agency properly investigates, tracks, and monitors physical and sexual abuse in nursing facilities in a timely manner.

Scope

The audit covered physical and sexual abuse complaints reported to the Survey Agency by nursing facilities in the State of Alabama during CY 2002. We did not assess the internal controls of the Survey Agency.

Survey Agency officials did not wish to have an exit conference to discuss the findings and recommendations presented in our draft report. The OIG extended an offer to meet and discuss our findings both before and after the draft report was issued. However, on May 14, 2004, after a 2-week extension was granted, the Survey Agency provided written comments to our draft report.

Methodology

To accomplish our objectives, we requested the Survey Agency provide a universe of all physical and sexual abuse complaints received for CY 2002. The universe contained a total of 311 complaints originating from 141 nursing facilities. We arrayed the complaints by facility and then by the number of complaints per facility. A judgmental sample of six nursing facilities was chosen based on the number of complaints per facility. Our selection of facilities ranged from the highest number of complaints to the lowest number of complaints reported to provide an adequate basis for comparison. Combined, there were 35 complaints arising from the six nursing facilities chosen for the review. While all of the 35 allegations of abuse occurred in nursing facilities, only 30 of the complaints were reported by the nursing facilities. The other five complaints were reported by the following sources: (1) three from a news reporter, (2) one from the Ombudsman, and (3) one from a resident's relative.

In addition to obtaining the universe of CY 2002 physical and sexual abuse complaints from the Survey Agency, we also obtained and reviewed:

- policies and procedures from the Survey Agency regarding the reporting and investigating of abuse allegations
- Federal and State criteria applicable to reporting and investigating abuse allegations

From the six nursing facilities chosen for our sample, we obtained and reviewed:

- complaints submitted to the Survey Agency during CY 2002
- the two previous surveys performed by the Survey Agency and/or CMS, including deficiencies and the plan of correction
- financial information
- staffing information
- employee screening methodology

We interviewed CMS officials, Survey Agency officials, Alabama Medicaid Fraud Control Unit (Fraud Unit) officials, the State Ombudsman, and the administrators and/or directors of nursing at the six nursing facilities chosen for our review.

Audit work was performed at: CMS Region IV office in Atlanta, Georgia; the Survey Agency, the Fraud Unit, and the Alabama Ombudsman's Office in Montgomery, Alabama; and our Birmingham field office. Audit work was also performed at six nursing facilities throughout the State of Alabama. Fieldwork was conducted from

January 2003 through December 2003. We conducted our review in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

Our review of physical and sexual abuse complaints reported to the Survey Agency for CY 2002 revealed that the Survey Agency is not: (1) investigating allegations timely; (2) appropriately tracking and monitoring abuse allegations; (3) updating the registry in accordance with time requirements; and (4) requiring nursing facilities to submit abuse complaints timely. As a result, the safety and well being of residents of nursing facilities is being threatened. We are recommending that action be taken to correct each of these deficiencies to comply with Federal and State regulations and guidelines.

The Survey Agency Does Not Investigate Allegations Timely

We found that the Survey Agency is not investigating allegations of physical and sexual abuse within established timeframes. In 3 out of 35 complaints in the sample, the Survey Agency did not investigate complaints within established timeframes. For these 3 complaints, the Survey Agency had assigned a priority to investigate within 10 working days. However, the Survey Agency did not investigate the complaints until after the 10 working days had lapsed. To avoid further abuse to nursing facility residents, an investigation should be performed within a timely manner.

According to a CMS directive and the policies and procedures of the Survey Agency, for CY 2002, abuse complaints are assigned priorities for investigation as follows: 2 working days for immediate jeopardy; 10 working days for actual harm; and the next onsite visit for all other complaints. In addition, CMS requires for recertification surveys to be completed prior to the Survey Agency investigating abuse complaints.

The complaints are not being investigated or closed in a timely manner, which has resulted in a 4-year backlog of abuse allegations. From the universe of 311 physical and sexual abuse complaints provided by the Survey Agency for CY 2002, there was a backlog of 180 complaints that had not been investigated and closed by the Survey Agency as of the time of our audit. This backlog represented 58 percent of the complaints in the universe. The Survey Agency informed CMS of the backlog in March 2002, yet the backlog of abuse allegations has continued. As of December 3, 2003 the Survey Agency reported “a long backlog of cases awaiting desk review due to resource issues.”

Survey Agencies are required by CMS to first conduct all recertification surveys prior to investigating any abuse allegation complaints. Due to the priority of recertification surveys and resource issues, the Survey Agency is unable to comply with Federal and State regulations that require them to investigate abuse complaints within the prescribed timeframes.

All Complaints Received by the Survey Agency Were Not Appropriately Tracked and Monitored

CMS's State Operations Manual, Chapter 7, Section 7700, states in part that immediately after receipt of an abuse allegation, the Survey Agency is to establish a file. Further, it states that a system should be used to facilitate tracking and control of the allegation until it is entered into CMS's Online Survey Certification and Reporting Complaint Subsystem.

The Survey Agency's tracking system does not reflect all physical and sexual abuse complaints submitted by the nursing facilities. We selected 35 of 311 complaints in the Survey Agency's complaint log for CY 2002 for our review. Of these 35 complaints, 30 were reported by 6 nursing facilities, 3 were reported by a news reporter, 1 was reported by the Ombudsman, and 1 was reported by a resident's relative.

We visited each of the six nursing facilities to test the completeness of the Survey Agency log. At the facilities, we requested all physical and sexual abuse complaints reported to the Survey Agency during CY 2002. The 6 facilities reported a total of 64 complaints. Representatives of the Survey Agency later explained the difference between the 64 complaints submitted by the nursing facilities and the 30 complaints in the Survey Agency's complaint log is due to 34 complaints either being allegations that did not rise to the level of physical or sexual abuse or the evidence documented in the investigation performed by the facility did not warrant any further review. Based on this explanation, 34 of the 64 complaints were dropped without any record of their disposition by the Survey Agency.

We also found that the Survey Agency does not consistently track and monitor all complaints. As previously mentioned, reviews can be performed by either an onsite investigation or by desk review. We found that complaints that were assigned a desk review would sometimes be assigned a complaint number and at other times be placed in the nursing facility's file without a complaint number. The tracking system utilized by the Survey Agency only reflected complaints that were assigned complaint numbers. According to the Survey Agency, complaint numbers should only have been assigned to those complaints with an onsite investigation priority. However, the Survey Agency inconsistently applied complaint numbers to complaints that were assigned a desk review.

We are concerned that inadequate tracking and monitoring of complaints may affect the quality of care received by the residents. If appropriate remedies are not made, additional abuses may needlessly occur.

We believe the Survey Agency does not have adequate policies and procedures addressing the receipt and disposition of all abuse complaints received. While the current policies and procedures adequately address the triage process, they do not provide detailed instructions to address whether the complaints are investigated onsite or through a desk review. This lack of guidance has led to an inconsistent treatment of desk reviews. In addition, the policies and procedures do not include instructions to track and monitor

complaints that are reported but do not rise to a level that warrants further review by the Survey Agency.

Abusive Employees Were Not Updated on the Registry

We found one complaint in the sample where the Survey Agency substantiated findings of physical or sexual abuse against an employee; however, the Survey Agency did not update the registry within 10 working days of the finding. The abuse was substantiated on August 19, 2002 yet, as of January 13, 2004 over a year later; the registry has not been flagged for this employee.

Under 42 CFR § 483.156 and § 488.335, and CMS's State Operations Manual Chapter 7, Section 7702 J, when the Survey Agency finds that an employee is abusive, the registry must be updated within 10 working days of the finding.

Since the employee has not been flagged on the registry after abuse has been substantiated, the employee is free to find employment in other direct care settings, potentially placing other residents at risk for abuse.

All of the nursing facilities chosen for review stated the registry is used as a tool for screening and hiring individuals for employment. If the registry cannot be relied upon as an accurate screening tool, nursing facilities will have to resort to spending additional money for background checks on all applicants of direct care positions. The money that will be spent on background checks could be better spent on patient care for the residents of the nursing facilities. To date, we have not obtained an explanation as to why the registry is not being updated within prescribed timeframes.

The Survey Agency Is Not Requiring Nursing Facilities to Report Abuse Allegations in Accordance With Federal and State Regulations

When the Survey Agency receives complaints from nursing facilities that are not within the timelines established by State and Federal regulations, they should cite the facility with deficiencies. With two exceptions, we did not find any evidence that this was occurring.

According to 42 CFR § 483.13, violations of abuse must be reported immediately to the facility administrator and the Survey Agency; also, the investigation results must be reported to the Survey Agency within 5 working days of the incident. Alabama licensure rules require nursing facilities to notify the Survey Agency within 24 hours of an occurrence of abuse.

Out of 35 complaints in our sample, we identified the following reporting violations of Federal and State regulations committed by nursing facilities:

Nursing Facility Violation	Number of Complaints
Nursing facility employees did not notify nursing facility authorities within 24 hours of occurrence	6
Nursing facilities did not notify the Survey Agency within 24 hours	9
Nursing facilities did not submit the investigative report to the Survey Agency within 5 working days	8

(The results in the above table are not mutually exclusive.)

As mentioned in a previous finding, 5 of our 35 complaints were not reported by the nursing facility. These five complaints were reported from other sources. When an employee does not notify the nursing facility and/or the facility does not notify the Survey Agency immediately, the investigation by the Survey Agency is further delayed. Thus, additional abuse could occur between the time the abuse occurred and the time the abuse was reported. Also, the abused residents may not be protected from reprisal by the perpetrator. We believe the Survey Agency would encourage more timely submissions if they would cite deficiencies for all late submissions of complaints.

In Conclusion, the Survey Agency Is Not:

- investigating allegations timely
- appropriately track and monitoring abuse allegations
- updating the registry in accordance with time requirements
- requiring nursing facilities to submit abuse complaints timely

RECOMMENDATIONS

Based on these findings, we recommend that the Survey Agency:

- Investigate complaints within established timeframes. We also recommend the Survey Agency notify CMS of all abuse complaint backlogs and request assistance from CMS to help restore the workload to a manageable level.
- Improve policies and procedures to include detailed instructions for tracking and monitoring all complaints received.
- Update the registry in accordance with Federal requirements and place a higher priority on abuse complaints that have already been substantiated by the nursing facilities.

- Encourage nursing facilities and their employees to report abuse allegations in accordance with Federal and State regulations by citing the nursing facilities with deficiencies for those who do not report abuse timely.

THE SURVEY AGENCY’S COMMENTS

The Survey Agency agreed with our recommendations relating to the timely investigation of abuse complaints and adequate tracking of the receipt of complaints. The Survey Agency, however, did not agree with the recommendations related to annotating abusive certified nurse aides (CNAs) into the registry and requiring nursing facilities to submit complaints within established timeframes.

The Survey Agency Does Not Investigate Allegations Timely

The Survey Agency’s Comments

The Survey Agency concurred with our recommendation, but respectfully disagreed that the three complaints cited were not investigated within established timeframes. As follows, the Survey Agency stated these 3 complaints were investigated within 10 working days:

- Complaint #02-00913 – investigated within 7 working days
- Complaint #02-00315 – prioritized as a 10 day complaint on May 3, 2002 and was investigated within 3 working days on May 8, 2002
- Complaint #02-00361 – originally prioritized as a desk investigation and upgraded to a 10 day complaint on May 21, 2002, when further information was received, and was investigated on May 29, 2002, within 6 working days

The Survey Agency acknowledged the backlog of abuse complaints. The Survey Agency claimed CMS requirements and staff shortages as the cause of the backlog of abuse complaints. While additional funding has been requested to the Alabama Legislature for the past 3 years to help alleviate the staff shortages, each request has been denied.

OIG’s Response

We acknowledge the Survey Agency’s agreement with our recommendation to investigate all complaints within established timeframes. However, we respectfully disagree with the Survey Agency that three complaints were investigated within established timeframes.

We approached this finding based upon a CMS directive and the policies and procedures of the Survey Agency, which states that for CY 2002 actual harm complaints are to be investigated within 10 working days of receipt of the complaint. According to the Survey Agency’s policies and procedures, in order to arrive at the prioritization phase, “A

24 hour report may not be prioritized until the SA [Survey Agency] receives the 5 working day investigation.”

In reviewing the three complaints in question, we counted 10 working days from the date the Survey Agency received the 5 working day investigation. The complaints are discussed as follows:

Complaint #02-00913

Date alleged incident occurred – October 1, 2002
Date the facility 24-hour report was received by the Survey Agency – October 2, 2002
Date the facility 5 working day investigative report was received by the Survey Agency – October 4, 2002
Investigation priority assigned by the Survey Agency – “Investigate Within 10 days”
Date of the 10th working day from October 4, 2002 – October 21, 2002
Date the Survey Agency investigated the complaint – October 22, 2002

Therefore, complaint #02-00913 was not investigated within 10 days.

Complaint #02-00315

Date alleged incident occurred – Saturday, April 6, 2002
Date the facility 24-hour report was received by the Survey Agency – April 8, 2002
Date the facility 5 working day investigative report was received by the Survey Agency – April 12, 2002
Investigation priority assigned by the Survey Agency – “Investigate Within 10 days”
Date of the 10th working day from April 12, 2002 – April 26, 2002
Date the Survey Agency investigated the complaint – May 8, 2002

Therefore, complaint #02-00315 was not investigated within 10 days.

Complaint #02-00361

Date alleged incident occurred – April 9, 2002
Date the facility 24-hour report was received by the Survey Agency – April 9, 2002
Date the facility 5 working day investigative report was received by the Survey Agency – April 9, 2002
Investigation priority assigned by the Survey Agency – “Investigate Within 10 days”
Date of the 10th working day from April 9, 2002 – April 23, 2002
Date the Survey Agency investigated the complaint – May 29, 2002

While the Survey Agency stated in their response that this complaint was “upgraded” on May 21, 2002 there was no evidence in the complaint file of such an “upgrade”, nor did the Survey Agency provide additional support in their response.

Therefore, complaint #02-00361 was not investigated within 10 days.

All Complaints Received by the Survey Agency Were Not Appropriately Tracked and Monitored

The Survey Agency’s Comments

In written comments to the draft report, the Survey Agency concurred with our recommendation to improve the tracking and monitoring system for abuse complaints that are received. However, the Survey Agency respectfully disagreed with our finding that 34 complaints were dropped without any record of their disposition by the Survey Agency. The Survey Agency stated, “It is our position that most of the 34 examples you noted were not cases that rose to the level of physical or sexual abuse that required further investigation.” The Survey Agency noted that altercations involving resident on resident abuse between cognitively impaired residents is not to be considered as abuse.

In final comments to this finding, the Survey Agency stated it “will review its policies and procedures to determine where improvements can be made to ensure that all complaints are appropriately tracked and monitored in accordance with CMS requirements.”

OIG’s Response

The Survey Agency noted that “**most of the 34**” (emphasis added) complaints did not rise to the level of physical or sexual abuse that required further investigation.

We do not agree because we are concerned that some of these complaints may have been of a serious nature, yet were not investigated by the Survey Agency. Specifically: (1) the Survey Agency does not know if the cases are inappropriately dropped and (2) our analysis shows 18 of the 34 complaints were of a very similar nature as those in the sample, yet were not investigated by the Survey Agency

Regarding resident on resident sexual abuse between cognitively impaired residents, the Survey Agency did not provide documentation stating that resident on resident sexual abuse is to be classified as an accident rather than an abuse allegation.

Abusive Employees Were Not Updated on the Registry

The Survey Agency’s Comments

The Survey Agency respectfully disagreed with our finding and recommendation related to employees with substantiated complaints of abuse against them not being updated on the registry. The Survey Agency stated, “We do not concur with this recommendation. The nurse aide abuse registry is presently being updated in accordance with federal requirements”.

The Survey Agency provided the following responses as support for their disagreement:

Complaint #02-00147

“The survey agency did not substantiate this allegation of abuse. The perpetrator remains in good standing on the nurse aid registry. The surveyor incorrectly marked under conclusion that the allegation was substantiated. Please see the enclosed cover sheet for this case in which the surveyor identifies that the allegation was not substantiated.”

Complaint # 02-00623

“Although the surveyor substantiated this case, a review of this case was conducted by the complaint unit supervisor and division attorney who concluded there was not enough evidence to prevail at a hearing.” The Survey Agency contends it reversed the surveyor’s decision that abuse was substantiated.

The Survey Agency also stated, “The contention of the OIG that an aide must be listed on the abuse registry within ten days of a finding of abuse would, if followed, cause our agency to violate this unambiguous federal regulation.”

OIG’s Response

We acknowledge that Federal regulations allow for an appeal process for CNAs found guilty of abuse by the Survey Agency. However, in one complaint where the Survey Agency substantiated abuse, the time elapsed far exceeded the time allowed by Federal regulations to complete the appeal process.

Complaint #02-00147

We modified the report to reflect the removal of this complaint from our finding.

Complaint #02-00623

We found no information in the complaint file to indicate that the surveyor’s decision to substantiate abuse had been reversed, nor did the Survey Agency provide any evidence to support their comments. Our finding is based on information contained in the complaint file.

The example cited by the Survey Agency as the unknown complaint has been removed from our report.

The Survey Agency Is Not Requiring Nursing Facilities to Report Abuse Allegations in Accordance With Federal and State Regulations

The Survey Agency’s Comments

The Survey Agency disagreed with our recommendation relating to the Survey Agency not requiring nursing facilities to report abuse allegations timely.

In response to the recommendation that the Survey Agency should place a higher priority on abuse complaints that already have been substantiated by nursing facilities, the Survey

Agency stated, “We do not concur with this recommendation. The state agency is required to follow the State Operations Manual and CMS policies about the prioritization of complaints; we are not free to deviate from those existing priorities”.

In response to the recommendation that the Survey Agency encourage nursing facilities and their employees to report abuse allegations in accordance with Federal and State regulations by requesting civil monetary penalties or fines for those who do not report abuse timely, the Survey Agency stated, “We do not concur with this recommendation... these OIG-suggested remedies are not actually available to us.” Further, the Survey Agency stated, “CMS policy is to impose civil money penalties only after a facility has been cited for a deficiency and offered an opportunity to correct, with a few exceptions that would not apply here. An immediate CMP remedy is not currently available in cases where the only deficient practice is failure to file a timely report.” Further, the Survey Agency stated, “The suggestion that nursing home employees who fail to timely report abuse be referred for criminal prosecution is also problematic.” Also in their comments they state, “the use of criminal prosecutions and fines is not available in the vast majority of cases where abuse is not reported or is reported in an untimely manner”.

OIG’s Response

The Survey Agency recognizes the importance of investigating facility self-reports of abuse, and that they are actively exploring ways to commit additional resources to complaint and abuse investigations. The Survey Agency also agreed that they should encourage the timely reporting of abuse allegations.

We are encouraged to learn that the Survey Agency and the Medicaid Fraud Unit have jointly developed a procedure for referral of abuse and neglect cases for criminal prosecution.

However, we continue to believe the Survey Agency should place a higher priority on abuse complaints that already have been substantiated by nursing facilities. According to CMS’s Guiding Principles for Complaint Investigations, “...we expect that the SA will have at least three action levels based upon the alleged degree a resident’s safety is compromised or health status is jeopardized. These levels are immediate jeopardy, actual harm, and all other. The SA may develop additional priority assignments and response times for the other types of complaints.”

We have restated our recommendation.

APPENDIX



STATE OF ALABAMA DEPARTMENT OF
PUBLIC HEALTH

Donald E. Williamson, MD
State Health Officer

Office of Audit Svcs.

May 14, 2004

MAY 17 2004

Report Number: A-04-03-07027

RECEIVED

Mr. Charles J. Curtis
Regional Inspector General for Audit Services, Region IV
Office of Inspector General
Department of Health and Human Services
Room 3T41
61 Forsyth Street, S.W., #3T41
Atlanta, Georgia 30303

Dear Mr. Curtis:

Thank you for this opportunity to respond to the report of the Office of Inspector General entitled, "Survey of Physical and Sexual Abuse in Alabama Nursing Homes." We respond to the recommendations and findings of the OIG in the same order that they are presented in the report.

A. The OIG recommends that the State Agency investigate all complaints within established timeframes. We concur with this recommendation, but we disagree that the Alabama State Agency did not meet timeframes in the three examples cited by the OIG. The visit for complaint #02-00913 occurred within 7 working days. Complaint #03-00315 was prioritized as a 10-day complaint on May 3, 2002. The State Agency entered on May 8, 2002, within 3 working days. Complaint #02-00361 was originally prioritized as a desk investigation and upgraded to a 10-day complaint on May 21, 2002, when we received further information from the resident's son. This complaint was investigated on May 29, 2002, six working days later.

The State Agency does, however, acknowledge a backlog of facility self-reports of abuse where non-licensed individuals, such as certified nursing assistants, are named as perpetrators. The written policy of the Alabama State Agency with respect to these reports is the following: "If the origin is the result of a self-reported incident by a facility

Mr. Charles J. Curtis
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and the facility documents appropriate corrective action, i.e., staff suspended, terminated as a result of findings, measures put into place to ensure the safety of individuals has been addressed, etc., the above lists may not require a ten (10) day investigation priority." This policy has been reviewed and approved by CMS. It is therefore certainly consistent with federal regulations, the SOM, and CMS policies.

Because the state agency's staff resources are largely consumed with meeting deadlines established by federal statute and by CMS instructions, such as conducting recertification surveys in nursing homes every 12 months (mandated by federal statute), and investigating complaints prioritized as requiring visits within either 2 or 10 days, we have been unable to consistently complete investigations of these facility self-reports in a timely fashion.

This is a direct result of significant and persistent staffing shortages. Our agency is currently operating with only 56 percent of the staff we have estimated is necessary to complete all tasks assigned us by the Centers for Medicare and Medicaid Services. Faced with a staffing shortage of this magnitude, we have had to make extremely difficult operational decisions about the deployment of limited personnel. This dire staffing shortage is not unique to Alabama. A recent survey of state survey agency directors, with 22 states responding, showed that state agencies are operating with an average of only 79 percent of the staff required to do all of our federally-required work.

It is likely that neither Alabama, nor most other states, will be able to investigate complaints in a timely fashion until the Congress appropriates sufficient funding to survey and certification activities. For its part, the Alabama Department of Public Health has asked the Alabama Legislature for additional funding in each of the past three years, as the Department's top priority, to enable the Department to hire additional complaint surveyors. Well-publicized budget shortfalls within the state have caused these requests to be denied.

B. The OIG recommends that the State Agency improve policies and procedures to include detailed instructions for tracking and monitoring all complaints received. We concur in the recommendation to make improvements in the tracking and monitoring of all complaints received. We must respectfully disagree with the OIG's findings that 34 complaints were dropped without any record of their disposition by the State Agency. It is our position that most of the 34 examples you noted were not cases that rose to the level of physical or sexual abuse that required further investigation.

Perhaps we were not sufficiently clear with the OIG concerning our intake process. During the complaint intake process all complaints and facility reports are reviewed. Many times as a result of this review it is determined that the reported incident does not constitute an allegation of physical or sexual abuse. For example a minor injury

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of unknown origin in which there are no suspicious circumstances is not treated as an allegation of physical abuse. Examples include minor skin tears and small bruises. In addition CMS has instructed the survey agency that altercations and other inappropriate behaviors between cognitively impaired residents are not to be considered as abuse. When the facility has appropriately intervened to protect residents and prevent further altercations the State Agency would regard this matter as being appropriately resolved without the need for investigation. Also complaints received by surveyors during the course of a survey are investigated during that survey and adverse findings are included in the survey results. If each of these events were assigned a complaint number and investigated the backlog of complaint investigations would be even greater.

The State Agency will review its policies and procedures to determine where improvements can be made to ensure that all complaints are appropriately tracked and monitored in accordance with CMS requirements.

C. The OIG recommends that the State Agency update the [nurse aide abuse] registry in accordance with federal requirements. We do not concur with this recommendation. The nurse aide abuse registry is presently being updated in accordance with federal requirements. Adoption of the OIG suggestion to update the registry within 10 days of a finding of abuse by this agency would cause us to violate a federal regulation and explicit instructions from CMS. The conclusions of the OIG are based on what we believe is an erroneous reading of federal law, one that is directly contradicted by CMS regulations.

Federal regulations require the state survey agency to offer a nurse aide a due process hearing, *with at least 30 days prior notice*, before the aide may be placed on the abuse registry. 42 CFR Sec. 488.335. The contention of the OIG that an aide must be listed on the abuse registry within ten days of a finding of abuse would, if followed, cause our agency to violate this unambiguous federal regulation.

We specifically disagree with the OIG findings with respect to the cases in its sample, for the following reasons:

Complaint #02-00147

The survey agency did not substantiate this allegation of abuse. The perpetrator remains in good standing on the nurse aid registry. The surveyor incorrectly marked under conclusion that the allegation was substantiated. Please see the enclosed cover sheet for this case in which the surveyor identifies that the allegation was not substantiated.

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Complaint #02-00623

Although the surveyor substantiated this case, a review of this case was conducted by the complaint unit supervisor and division attorney who concluded there was not enough evidence to prevail at a hearing. The alleged abuse involved a resident whose wheelchair hit a door while the resident was under the care of a facility employee. The only witness to the event stated that she is not sure whether the employee intended to allow the wheelchair to hit the door. Proving that the wheelchair was intentionally, and not accidentally, pushed into the door by the employee would have been a critical element in proving abuse in this case. There was simply no evidence of intent available to bring forward to a hearing.

Unknown Complaint

The OIG cites a report from redacted Nursing Home that states, "...employee become abusive to a resident, the nursing facility discovered this employee had been terminated from another nursing facility due to abusive behavior." The State Agency can find no evidence that this facility ever sent us a report stating that the CNA named had abused a resident. In addition, HC-C.5.PS-2/49, redacted investigative information for 02-00894, does not document that this CNA was terminated from redacted for abuse. It only documents, "The facility found out she was terminated from her employment at redacted We requested a reference & found that she was in fact employed and terminated".

D. The OIG recommends that the State Agency place a higher priority on abuse complaints that already have been substantiated by nursing facilities. We do not concur with this recommendation. The state agency is required to follow the State Operations Manual and CMS policies about the prioritization of complaints; we are not free to deviate from those existing priorities. We do, however, recognize the importance of investigating facility self-reports of abuse. We are actively exploring ways to commit additional resources to complaint and abuse investigations.

E. The OIG recommends that the State Agency encourage nursing facilities and their employees to report abuse allegations in accordance with Federal and State regulations by requesting civil monetary penalties or fines for those who do not report abuse timely. We do not concur with this recommendation. While we agree that we should encourage the timely reporting of abuse allegations, for reasons detailed below, these OIG-suggested remedies are not actually available to us.

This part of the OIG report is more in the nature of a suggestion than an actual finding; it does not cite a violation of federal or state law or CMS procedures. Its only basis is the OIG's own opinion that the State Agency "should" in effect establish a new

Mr. Charles J. Curtis
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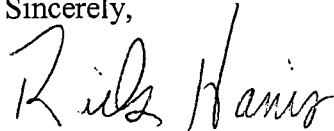
procedure for punishing those who fail to make abuse reports to the Agency in a timely fashion by either (1) referring facilities to CMS with a request for the imposition of a civil money penalty, or, (2) referring facility employees who fail to make timely reports to law enforcement. Unfortunately, these interventions are not actually available to us.

CMS policy is to impose civil money penalties only after a facility has been cited for a deficiency and offered an opportunity to correct, with a few exceptions that would not apply here. An immediate CMP remedy is not currently available in cases where the only deficient practice is failure to file a timely report.

The suggestion that nursing home employees who fail to timely report abuse be referred for criminal prosecution is also problematic. State law requires physicians, nurses, and other, "caregivers," to report to the Department of Public Health all allegations and suspicions of abuse inflicted on nursing home residents. The term, "caregiver," is further defined in the act as an individual who is a family member, a friend, or someone who has volunteered to care for an individual or who has contracted to care for an individual. This definition is written in a way that it does not include certified nursing assistants or other low-level nursing home employees. Unfortunately, most of the witnesses to nursing home abuse are CNAs and other low level employees, so the use of criminal prosecutions and fines is not available in the vast majority of cases where abuse is not reported or is reported in an untimely manner. We share the OIG's belief that the judicious use of criminal prosecutions, where available, would discourage abuse and encourage timely reporting of abuse in facilities. Subsequent to the audited time period (2002) the state agency and the Medicaid Fraud Unit have jointly developed a procedure for referral of abuse and neglect cases for criminal prosecution.

Thank you for the opportunity to reply to your report. Please feel free to contact us if you have any further questions or instructions regarding this reply.

Sincerely,

A handwritten signature in black ink, appearing to read "Rick Harris". The signature is fluid and cursive, with the first name "Rick" and last name "Harris" clearly distinguishable.

Rick Harris, Director
Bureau of Health Provider Standards

RH/RTS
Attachment
cc: Anna DuBois

ABUSE CRITERIA

Facility: REDACTED

Provider #: REDACTED

Accused Name: REDACTED

Complaint #: 02-00147

Surveyor's Name: REDACTED

Substantiated: Yes No ✓

Deficiency: Yes ✓ No

- ✓ (1) HCFA 1539, Certification and Transmittal (Old and New)
- ✓ (2) HCFA 670, Survey Team Composition and Workload Report
- ✓ (3) HCFA 562, Medicare/Medicaid Complaint Form
- ✓ (4) HCFA 2567, Statement of Deficiencies/Plan of Correction
- (5) HCFA 462L, Adverse Action Extract:
a. This form is required only if deficiencies were written as a result of complaint.
b. Provide a copy of the 462L from the LTC survey packet.
- ✓ (6) HCFA 672, Resident Census and Condition
- ✓ (7a) HCFA 802, Sample Matrix (List of sampled residents.)
- ✓ (7b) HCFA 802, Roster: List all residents and room #'s or obtain a list from facility
- (8) Complaint Intake Form
- ✓ (9) Narrative
- ✓ (10) Surveyor Worksheets
- none done (11) Facility's Investigation
- (12) Nurse Aide Abuse Registry Entry Form
- ✓ (13) Copy of Accused's Social Security Card & Driver's License
- (14) Other Pertinent Information

Complaint Unit Supervisor Instructions to Secretary

5/22/02

Send not list letter

ACCUSED'S INFORMATION:

Name: REDACTED

SS#: REDACTED

Address: REDACTED

DOB: REDACTED

City, State, Zip: REDACTED

ABUSE CRITERIA

Facility: REDACTED

Provider #: REDACTED

Accused Name: REDACTED

Complaint #: 02-00147

Surveyor's Name: REDACTED

Substantiated: Yes No ✓

Deficiency: Yes ✓ No

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 (14) Other Pertinent Information

Complaint Unit Supervisor Instructions to Secretary

5/22/02

Send not list letter.

ACCUSED'S INFORMATION:

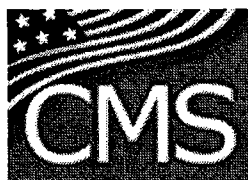
Name: REDACTED

SS#: REDACTED

Address: REDACTED

DOB: REDACTED

City, State, Zip: REDACTED



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October 14, 1999

Dear Survey Agency Director:

This letter provides operational guidance for the direction we issued on March 16, 1999 requiring that all complaints alleging actual harm in nursing homes be investigated within 10 days. We also reiterated the current requirement for onsite investigations of complaints alleging immediate jeopardy within two days. That memorandum further required that all complaint information be entered into OSCAR timely. This was intended to include results of all investigations of allegations of violations to Federal requirements whether or not there is also a related State licensure requirement.

Since March, we have been working with representatives from the Association of Health Facility Survey Agencies (AHFSA) to address States' concerns regarding implementation of this policy guidance and to establish specific guidance on a process for prioritizing complaints for investigation. We believe that this additional guidance will result in an improved and more nationally consistent process. To further assist implementing this guidance, key staff from each HCFA Regional Office will be meeting with the State SAs to discuss triage and prioritization of complaints, facilitate sharing examples of best practice complaint management, and discuss the manner in which implementation of this guidance will be evaluated.

We will continue to work on additional measures to improve the complaint process for nursing homes and other providers. We will be working with the States and relevant organizations during this process.

/s/

Rachel Block
Deputy Director

Enclosure

GUIDING PRINCIPLES FOR COMPLAINT INVESTIGATIONS

The following guidance will enhance the ability of State Survey Agencies (SA) and HCFA Regional Offices (RO) to respond to complaints. The complaint investigation is expected to conform to existing Federal rules and guidelines

including Appendix P Survey Protocol for Long Term Care Facilities Section VII Abbreviated Standard Surveys.

Information regarding the care, treatment and services provided to beneficiaries can come from a variety of sources and in a number of formats. Complaints may come directly from beneficiaries, beneficiaries' family members, health care providers, concerned citizens or other public agencies. Report sources may be verbal or written. In some instances, the complainant may request anonymity. These complaint investigation guidelines focus on responding to the complaints of individuals.

INTAKE PROCESS

The point of complaint receipt is a critical fact-finding and decision-making junction. Information coming from many sources (beneficiaries, providers, general public or partners, etc.) requires expert, professional evaluation to determine the most appropriate next steps. Comprehensive information should be collected during the intake process to allow for proper triage to occur, particularly to determine which complaints warrant the highest priority attention. Each SA is expected to have written policies and procedures to ensure that the appropriate response is taken for each complaint. This structure needs to include response time lines and an orderly process to document actions taken by the SA in responding to every complaint.

Information To Collect From Complainant

It is not always possible to capture complete information necessary to make important decisions about the complainants' allegations. In instances where written complaints are received, either subsequent verbal and/or written communication may be necessary to obtain and/or provide comprehensive information. In the case of complaints received verbally (telephone or face-to-face meetings), an important opportunity exists to obtain complete information to assist with the decision-making and investigative processes and to provide information to beneficiaries or concerned individuals.

To obtain all relevant details regarding the complainant and the allegation(s) at the time the complaint is received, the following information should be collected:

- complainant information (name, address, telephone, etc.)
- individuals involved and affected, witness and accusers
- allegation category(ies) (abuse, neglect, dietary, nursing services, etc.)
- narrative/specifics of allegation/incidence
- if the complainant believes this is an isolated event or a systemic problem
- date/time of allegation
- date/time/frequency of incidence occurrence
- facility name including location (e.g. unit, room, floor) of allegation/incident/occurrence
- why the complainant believes the incident occurred

- how the complainant thinks the incident occurred
- whether or not other courses of action were initiated, including other agencies, provider contacts made, to resolve the complaint issue(s) and the response/resolution obtained if any
- the complainant's expectation/desire for resolution/remedy, if any

Information To Provide To Complainant

An effective complaint intake, screening and referral system must not only collect and process information from a variety of sources, but it also must provide information to assist the complainant in resolving his/her conflicts. The information may be provided verbally during initial or subsequent telephone discussions or may be provided through written correspondence when acknowledging complaint receipt. In either case, the following elements should, at a minimum, be provided as part of all complaint intake, screening and referral programs:

- the SA's policies and procedures for handling complaints including the scope of your regulatory authority and any considerations pertaining to confidentiality of the complaint.
- the course of action that your agency will take and time frames that may be expected.
- information about other appropriate agencies who could provide assistance including the phone number and name of contact person, if one is known.

Self-Reported Incidents

Incidents that are self-reported would not automatically be considered a "complaint" against the facility, but they could indicate serious situations, and should be triaged applying the same criteria as complaints. Intake of this information should be part of the State complaint process including triage and follow up, if necessary.

TRIAGE and PRIORITY ASSIGNMENT

Once it has been determined that the complaint allegation(s) fall within the scope of the agency's and program's authority, the agency must triage the complaint to determine the severity and urgency of the allegations, so that appropriate and timely action can be pursued.

An assessment of each complaint must be made by an individual who is professionally qualified to evaluate the nature of the problem based upon their knowledge of current standards of practice and Federal requirements. As part of the SA triage process, additional information should be evaluated by the SA to determine the severity and urgency of the complaint, including the facility's compliance history, date of the complaint, the facility's quality indicators, or supporting information received from other programs such as the ombudsman program or protection and advocacy program. This process may require additional contact with the complainant. All information will be gathered and evaluated; the complaint will be prioritized; and the date when the complaint

is to be investigated will be scheduled within 10 working days of its receipt, unless there are extenuating circumstances that impede the collection of relevant information within this time frame.

At a minimum, HCFA expects the SA to investigate all complaints of alleged violations of the Federal participation requirements. Therefore, we expect that the SA will have at least three action levels based upon the alleged degree a resident's safety is compromised or health status is jeopardized. These levels are immediate jeopardy, actual harm, and all other. The SA may develop additional priority assignments and response times for the other types of complaints. However, the focus of these written guidelines is on complaints alleging immediate jeopardy or actual harm. The current State Operations Manual should be followed regarding management of complaints that do not fall within the definition of immediate jeopardy or alleged actual harm.

Immediate Jeopardy - The requirement regarding investigation when a finding of immediate jeopardy is present remains unchanged. Section 42 CFR 489.3 defines immediate jeopardy as, "a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." Immediate jeopardy, immediate and serious threat, and serious and immediate threat are interchangeable terms. In a situation where the determination is made that immediate jeopardy is present and on-going, the SA is required to investigate within 2 working days of receipt of the complaint. If the triage process by the SA determines that the immediate jeopardy has been removed, a 2-day investigation is not required. This is not a change from current policy, and existing guidance provided in regulation and operations manuals including HCFA transmittal 273, and Appendices P and Q are to be followed.

Actual Harm - Complaints may be received where a resident has experienced (or is alleging) actual harm that does not rise to the level of immediate jeopardy. In cases where the SA makes the determination that a higher level of actual harm is present, the investigation is to be initiated within 10 working days of its receipt (a determination of immediate jeopardy continues to require investigation within two working days of receipt of the complaint). Ultimately the SA is expected to be able to share the logic and rationale that was utilized in triage and prioritization of the complaint for investigation. The SA response must be designed to stop ongoing harm or to prevent harm from occurring. The degree of harm to a resident will be a key factor in setting priorities.

Prioritizing Actual Harm Complaints

We suggest the State adopt criteria that describe how it will differentiate higher level of alleged actual harm to residents from other complaints.

Due to other priority workloads and the receipt of other complaints needing more immediate response, States may not be able to meet this standard uniformly. Under these circumstances, States should concentrate on complaints that allege a higher level of actual harm. States will continue to be expected to monitor the status of investigations and work them based on the greatest need. The following examples of allegations of a higher level of harm

are provided to assist the SA in establishing priorities in response to complaints alleging harm:

- resident is intimidated/threatened;
- resident is physically abused - spitting/slapping/sticking with sharp object/pushing/pinching;
- unexplained/unexpected death, with circumstances indicating that there was abuse or neglect;
- resident to resident sexual assault/sexual harassment/coercion;
- falls resulting in fracture (e.g. handrails not secured);
- inappropriate use of restraints resulting in injury;
- inadequate staffing which negatively impacts on resident health, and safety;
- failure to obtain appropriate care or medical intervention, i.e. failure to respond to a significant change in the resident's condition.

INVESTIGATION

Complaint Investigation Response

An investigation is an onsite review to determine the likelihood that the situation occurred or is occurring, determine whether a deficient practice is or was present, and assess the degree of harm to any resident(s). There may be circumstances when information gathered by the SA may mitigate the need for an onsite visit. The SA may determine that an instance self-reported by a facility has been fully investigated. If the report identifies a response that corrective action has been taken, and the SA believes the information to be credible, an onsite visit would not be required. It also would not be necessary for a SA investigation if another SA or reliable entity has or is in the process of completing an investigation that meets the SA's requirements. When the SA refers the complaint to another agency or entity (e.g., law enforcement, Ombudsman, licensure agency, etc.) For action, the SA must obtain a written report on the results of the investigation. Regardless of who conducts the investigation, the SA has the responsibility for assuming a facility's compliance with Federal participation requirements.

The complaint process must be timely and responsive. However, HCFA does not expect a complaint investigation to be completed and reports finalized within 10 working days.

Complaint Investigation Findings and Reports

Each agency should establish reporting policies, procedures and formats including report language targeted to the specific audience. The complainant and the provider investigated are expected to be provided with a written report of the complaint investigation findings to allow an opportunity for further discussion/actions and serve as a summary record of the investigation.

State Agencies and ROs must follow provisions relating to complaint reporting and follow-up actions contained in the State Operations Manual and

enforcement regulations. Many States have specific State laws addressing the response to complaints or self-reported incidents. Whenever possible, State and Federal requirements should be integrated to avoid unnecessary duplication. ROs should accept State requirements which meet the intent of the Federal requirements. If the SA intends to recommend a civil money penalty, past serious noncompliance is expected to be recorded on the statement of deficiencies under tag number F698. The following principles should be used to guide preparation of the complaint report:

Complaint Process and Report:

- Acknowledge the complainant's concern(s).
- Identify your agency's regulatory authority and limitations.
- Provide an explanation of your agency's decision-making process including definitions of terms used (i.e., substantiated or validated, unsubstantiated or not validated, etc.).
- Provide a summary of investigation method (i.e., on-site visit, written correspondence, telephone inquiries, etc.).
- Provide date(s) of investigation.
- Provide a summary of your agency's finding (Note: To the extent possible the report summarizing the results of the investigation should not compromise the anonymity of individuals, or include specific situations that may be used to identify individuals, when anonymity has been requested or is appropriate in the judgement of the SA).
- Identify follow-up action, if any, to be taken by your agency (i.e., follow-up visit, plan of correction review, no further action, etc.).
- Identify appropriate referral information (i.e., other agencies that may be involved).
- Inform of continued monitoring if that is one of the actions that will be taken.

RO Responsibility:

SAs are required to enter complaint data into the Online Survey, Certification and Reporting System (OSCAR) complaint subsystem. Sections 3281-3284 of the State Operations Manual provides instructions for encoding the results of all complaints resulting in citations of Federal deficiencies. Where an investigation finds one or more violations of Federal requirements, the findings must be cited under appropriate tags and entered into OSCAR even if they are also going to be entered into a State licensure system. Since this information is essential to the effective management of the survey and certification program, it is important that States enter comprehensive complaint data into the OSCAR system in a timely basis.

Monitoring of operational guidelines for handling complaints is a responsibility of the RO as part of its ongoing assessment of SA performance.

Evaluation of the SA's complaint management program is to ensure that intake, decision making, investigations and subsequent actions conform to Federal requirements. At a minimum, RO staff are expected to be onsite in the SA annually to evaluate management of the complaint program. SAs and ROs

will need to review and assess these procedures.

HCFA is interested in receiving comments relating to more specific criteria, ongoing assessment of complaint priorities, rescheduling of assigned complaints due to newer concerns requiring more immediate response, and use of the survey process in addressing complaints.

Last Modified on Monday, December 01, 2003



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Centers for Medicare & Medicaid Services

7500 Security Boulevard, Baltimore MD 21244-1850

[CMS Telephone Numbers](#)



ACKNOWLEDGMENTS

This report was prepared under the direction of Charles J. Curtis, RIGAS. Other principal Office of Audit Services staff who contributed include:

Andrew Funtal, *Audit Manager*

Anna Dubois, *Senior Auditor*

Janet Mosley, *Auditor*

Maureen Bates, *Independent Report Reviewer*

For information or copies of this report, please contact the Office of Inspector General's Public Affairs office at (202) 619-1343.